## Department of Employe Trust Funds P.O. Box 7931 Madison, WI 53707-7931

Use of this form is optional. A letter providing the same information is equally acceptable.

## **APPEAL FORM**

(Use only to appeal your WRS coverage begin date or employment category.)

Please print o	r type.	
EMPLOYE INFORMATION		EMPLOYER INFORMATION
Social Security Number		Name
Name		Address
Mailing Address		
City, State, Zip		City, State, Zip
Under Wis. S regarding:	Stat. § 40.06 (1) (e), I hereby appeal the deci	ision of my employer to the Employe Trust Funds Board
	My eligibility for participation in the Wiscor	nsin Retirement System from ate) to (date).
	An employe may appeal the employer's de participating employe directly to the Board employment began on or after April 27, 19	etermination that the employe did not qualify as a different began prior to April 27, 1984. If 984, Wis. Stat. § 40.06 (1) (e) may limit the appeal only rior to the date the appeal is received by the Board.
	My employment category (general, executive, protective, teacher, elected official) from (date) to (date).	
	Employment category reported as	
	I believe the correct category is	
Please briefl <sub>!</sub>	Board if employment began prior to Janua	
_		
Date (MM/DD/CCYY)		Signature
Position Title		Daytime Telephone Number

Return completed Appeal Form to: Department of Employe Trust Funds, Attn: Appeals Coordinator, P.O. Box 7931, Madison, WI 53707-7931.